

MDR Tracking Number: M5-04-3235-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-26-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The psychiatric interview; psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes; and preparation of report of patient's psychiatric status, history, treatment, or progress for other physicians, agencies, or insurance carriers on 1/28/04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c) (1) and (6), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 1/28/04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 25<sup>th</sup> day of August 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

August 13, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-3235-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ----- external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in psychiatry and is familiar with the condition and treatment options at issue in this appeal. The ----- physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 53 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right shoulder. The patient reported that he was fixing the door a vehicle when he was hit in the right shoulder by a jack. The patient underwent x-rays and an MRI. The diagnoses for this patient have included right shoulder/clavical contusion, right clavicle fracture, and right cervical/brachial strain syndrome. Treatment for this patient's condition has included heat/ice, electrical stimulation, chiropractic adjustments, physical therapy and a work hardening program. On 1/24/04 the patient was sent for a psychiatric evaluation. This was ordered to provide pain management during work hardening and further treatment planning.

### Requested Services

Psychiatric interview, psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic

purposes, preparation of report of patient's psychiatric status, history, treatment, or progress for other physicians, agencies, or insurance carriers on 1/28/04.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor:*

1. Position Statement 5/22/04
2. Clinical Interview 1/28/04
3. Peer Review 11/30/03

*Documents Submitted by Respondent:*

1. No documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 53 year-old male who sustained a work related injury to his right shoulder on ----- . The ----- physician reviewer indicated that the patient has manifested continued shoulder pain, marked reduction of his pre injury activities with ADLs, and a variety of mood and coping strategy changes. The ----- physician reviewer also indicated that this patient required psychological evaluations for both diagnostic purposes and to better coordinate a treatment plan as well as determine if psychological issues are significant in this patient's condition. The ----- physician reviewer explained that the clinical evaluation revealed that this patient's current levels of anxiety and depression did not require any ongoing specific psychological or psychiatric care. Therefore, the ----- physician consultant concluded that the analysis of information data stored (99090) and prolonged E/M service (99358-52) on 9/22/03, 11/17/03, 12/8/03, and 12/31/03 were medically necessary to treat this patient's condition.

Sincerely,